

8069

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Pennsylvania</b> COUNTY <b>Philadelphia</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>		LENGTH OF STAY (in this place) <b>1 year</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Philadelphia</b>		<b>75X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50 Main Harbor</b>				STREET ADDRESS (If rural give location) <b>1501 N. 18th St.</b>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <b>MARION CANTY</b>				OF DEATH: <b>August 7 1955</b>			
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Feb. 6, 1924</b>	9. AGE last birthday <b>31</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Trucking</b>		11. BIRTHPLACE (State or foreign country): <b>Elliott, S. Caroline</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>James Canty</b>				14. MOTHER'S MAIDEN NAME: <b>Mary McCloud</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>yes</b> (If Yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <b>Crisfield Police Dept.-Crisfield, Md.</b>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Accidental Drowning -</b>							
ANTECEDENT CAUSE (S) DUE TO (B) <b>William M. Coulbourn, M. D.</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <b>Went swimming &amp; Drowned</b>							
19A. DATE OF OPERATION: <b>August 7, 1955</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. DIRECT CAUSE OF DEATH (If either, notify medical examiner) <b>Accidental Drowning</b>		21B. PLACE (Home, farm, factory, etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>Crisfield Somerset, Md.</b>			
21D. TIME (Month) (Day) (Year) (Hour) <b>August 7, 1955</b>		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <b>Was swimming about 5 minutes &amp; sank &amp; did not come up</b>			
22. I hereby certify that I attended the deceased from <b>7 1/2</b> was <b>dead before</b> that I last saw the deceased live on <b>10</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>W. M. Coulbourn</b>						DATE SIGNED <b>Aug 18-1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 19, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>U.S. National Cemetery</b>		LOCATION (City, town, or county) (State) <b>Beverly, New Jersey</b>	
DATE REC'D BY LOCAL REGISTRAR <b>August 18, 1955</b>		REGISTRAR'S SIGNATURE <b>Barlow S. Adams</b>		24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 22 1965

BUREAU V. S.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

8972

## CERTIFICATE OF DEATH

Reg. Dist. No. 261

## 1. PLACE OF DEATH:

COUNTY Somerset MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 X TOWN Crisfield 12 hours  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS McCready Mem. Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Somerset  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN Manokin X  
 STREET (If rural give location)  
 ADDRESS Box 73

## 3. NAME OF DECEASED:

(First) Infant

(Middle)

(Last) Collins

## 4. DATE OF DEATH:

(Month) (Day) (Year)  
 Aug. 11, 19 55

## 5. SEX:

Male

## 6. COLOR OR RACE:

Colored

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Infant

## 8. DATE OF BIRTH:

Aug. 11, 1955

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

1 day

Months Days Hours Min. 12

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

Infant

## 11. BIRTHPLACE (State or foreign country):

U.S.A. Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Hudson Riley Collins

## 14. MOTHER'S MAIDEN NAME:

Catherine Collins

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

"Mother" Catherine Collins

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0  
Immediate cause

(a) atelectasis

DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

12 hrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Aug. 11, 11: A.M., 1955, to Aug. 11, 11: P.M., 1955; that I last saw the deceased alive on Aug. 11, 1955, and that death occurred at 11: P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 25. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Aug. 12, 1955

Nellie D. Payne

Hudson Riley Collins, Father, Acting Funeral Director

Manokin, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. R.

AUG 22 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08074

8073

## CERTIFICATE OF DEATH

Reg. Dist. No. 268

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Somerset</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Wenona</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wenona</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>		STREET ADDRESS (If rural give location) <u>Main Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>OLIVE</u>	(Middle) <u>B.</u>	(Last) <u>CORBETT</u>	(Month) <u>Aug</u> (Day) <u>9</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Sept 17 - 1874</u>
9. AGE last birthday: <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Wenona Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>WESLEY WEBSTER</u>		14. MOTHER'S MAIDEN NAME: <u>SMITH CAREW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>James Corbett - son Wenona Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X		8 months	
IMMEDIATE CAUSE (A) <u>Cerebral vas. accident</u>			
ANTECEDENT CAUSE (S) <u>arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>arteriosclerosis</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dehydration</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec</u> , 19 <u>54</u> to <u>Aug</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May</u> , 19 <u>55</u> , and that death occurred at <u>7:30</u> P M, from the causes and on the date stated above.			
SIGNATURE <u>Leo M. Hickey</u>		ADDRESS <u>Prince Anne Rd</u> DATE SIGNED <u>8-12-55</u>	
M. D. <u>Leo M. Hickey</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/12/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wenona Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/15/55</u>		REGISTRAR'S SIGNATURE <u>Leo M. Hickey</u>	
		24. FUNERAL DIRECTOR <u>Leo M. Hickey</u> ADDRESS <u>St. Paul's Cemetery</u>	

RECEIVED

AUG 18 1955

BUREAU V. S.



08075

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8074 CERTIFICATE OF DEATH

Reg. Dist. No. 26.5

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Somerset</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Somerset</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>		
OR TOWN <u>Crisfield</u>			OR TOWN <u>Crisfield</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>McCreedy Hospital</u>			STREET ADDRESS (If rural give location) <u>Charlotte Ave.</u>		
3. NAME OF DECEASED: (First) <u>HARRY</u> (Middle) <u>GLADSTONE</u> (Last) <u>CROCKETT</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>August 21 1955</u>		
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	
8. DATE OF BIRTH: <u>1915</u>		9. AGE last birthday <u>40</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Seafood Industry</u>		11. BIRTHPLACE (State or foreign country): <u>Tangier Island, Va.</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>		13. FATHER'S NAME: <u>Herman Crockett</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche E. Crockett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) <u>Automobile accident</u>			
IMMEDIATE CAUSE			
(B) <u>Fractured Skull - Internal</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Injury - Shock</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Automobile Collision</u>			

19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) <u>On Road</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Near Marion Som. Md</u>	
21D. TIME (Month) (Day) (Year) (Hour) <u>Aug 20 1955</u> M. <u>11:30</u>		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>Collision Automobile</u>	
22. I hereby certify that I attended the deceased from <u>He was called</u> and that death occurred at <u>7:30 a.m.</u> from the causes and on the date stated above.					
SIGNATURE <u>Wm. H. Hearnshaw</u>		M.D. <u>Crisfield Md</u>		DATE SIGNED <u>Aug 22-1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>	
				LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Bartola S. Adams</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bradshaw &amp; Sons—Crisfield, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

William H. Crockett, M.D.  
DEPUTY MEDICAL EXAMINER  
FOR SOMERSET COUNTY, MD.

RECEIVED

AUG 25 1955

BUREAU V. S.



8075

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

COUNTY **Somerset** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Crisfield** LENGTH OF STAY (in this place) **30 days**  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **McCreedy Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Somerset**  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Crisfield** 39  
 STREET ADDRESS (If rural give location) **207 7th St.** 1

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
**CORRINE ROSA HANDY**

4. DATE (Month) (Day) (Year)  
 OF DEATH: **August 11 1955**

## 5. SEX:

6. COLOR OR RACE:  
**female colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):  
**married**

8. DATE OF BIRTH:  
**October 6, 1931**

9. AGE last birthday **23** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **laborer**

10B. KIND OF BUSINESS OR INDUSTRY:  
**Seafood Industry**

11. BIRTHPLACE (State or foreign country):  
**Crisfield, Md.**

12. CITIZEN OF WHAT COUNTRY?  
**USA**

## 13. FATHER'S NAME:

**Buster Snow**

## 14. MOTHER'S MAIDEN NAME:

**Gladys Purnell**

15. WAS DECEASED EVER IN U.S. ARMOE FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service)  
**no**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

**Richard Handy-207 7th St.-Crisfield, Md.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

576X  
 IMMEDIATE CAUSE

(A) **Intestinal obstruction**

INTERVAL BETWEEN ONSET AND DEATH

**7 days**

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) **Staphylococcus peritonitis**

DUE TO

**3-4 wks.**

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

**July 26**

## 19B. MAJOR FINDINGS OF OPERATION

**intestinal adhesions, Peritonitis**

## 20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 19, 1955**, to **Aug 11, 1955**, that I last saw the deceased alive on **Aug 11, 1955**, and that death occurred at **12:15 M.** from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)  
**Burial**

DATE THEREOF  
**Aug. 13, 1955**

NAME OF CEMETERY OR CREMATORY  
**Lawsonia Cemetery**

LOCATION (City, town, or county) (State)  
**Crisfield, Md.**

DATE REC'D BY LOCAL REGISTRAR  
**Aug 8/12/55**

REGISTRAR'S SIGNATURE  
**Betty Taylor**

## 24. FUNERAL DIRECTOR

**Bradshaw & Sons--Crisfield, Md.**

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU V. 1

AUG 15 1955

RECEIVED

8076

## CERTIFICATE OF DEATH

Reg. Dist. No. 765

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crisfield</b>		LENGTH OF STAY (in this place) <b>1 week</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crisfield</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>McCreedy Hospital</b>				STREET ADDRESS (If rural give location) <b>Cove St.</b>			
3. NAME OF DECEASED: (First) <b>ROBERT</b> (Middle) <b>L.</b> (Last) <b>HARLOW</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>August 10 19 55</b>			
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>1887</b>	9. AGE last birthday <b>68</b> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Engineer</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Plant</b>		11. BIRTHPLACE (State or foreign country): <b>Roanoke, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME: <b>unknown</b>				14. MOTHER'S MAIDEN NAME: <b>unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>216-05-3196</b>		17. INFORMANT & ADDRESS: <b>McCreedy Hospital—Crisfield, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Carcinoma bowel Esoph</b>						<b>unknown</b>	
ANTECEDENT CAUSE (S) DUE TO <b>site uncertain</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 1, 1955</b> to <b>Aug 10, 1955</b> , that I last saw the deceased alive on <b>Aug 10, 1955</b> , and that death occurred at <b>1:55p</b> M, from the causes and on the date stated above.							
SIGNATURE <b>C. Rawley</b>		M. D.		ADDRESS <b>Crisfield, Md</b>		DATE SIGNED <b>8/10/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>August 12, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Crisfield, Cemetery</b>		LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Aug 12, 1955</b>		REGISTRAR'S SIGNATURE <b>Betty Taylor</b>		24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 15 1955

RECEIVED

08078

8977

## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 260

Item 9, Film 185 8-16-55 et

1. PLACE OF DEATH COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monie</u> TOWN <u>Monie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monie</u> TOWN <u>Monie</u> STREET ADDRESS (If rural, give location) <u>/</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	<u>Henry</u>	<u>Thomas</u>	<u>Hopkins</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Nov. 3, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Waterman</u>		<u>Retired</u>	<u>Maryland</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>George H. Hopkins</u>		<u>Martha Shores</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<u>No</u>		<u>215-20-0291</u>	<u>Mrs. Henry Hopkins</u>
(If yes, give war or dates of service)		<u>No</u>	<u>Monie, Md.</u>

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>420.1</u> <u>Immediate cause</u> <u>(a) Acute coronary occlusion -</u> <u>Antecedent cause(s)</u> <u>Diseases or conditions, if any,</u> <u>giving rise to the above cause,</u> <u>stating the underlying cause last</u> <u>(b) Dead when I saw him</u> <u>(c)</u>		<u>—</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
SIGNATURE <u>R. H. Johnson, M.D. Deputy Medical Examiner</u>		DATE SIGNED <u>August 6-55</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>8-7-1955</u>	<u>Oriole Cemetery</u>
LOCATION (City, town, or county) (State)	<u>Oriole, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>8/6/55</u>	<u>R. H. Johnson, M.D.</u>	<u>Levin R. Wilson</u>
		ADDRESS <u>Princess Anne, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1955

BUREAU V. S.

8078

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X <b>TOWN Rehobeth</b>		<b>lifetime</b>		OR <b>TOWN Rehobeth</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <b>BESSIE</b>		(Middle) <b>McCARTER</b>		(Last) <b>JENKINS</b>		OF DEATH: <b>August 27 1955</b>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<b>Female</b>		<b>Colored</b>		<b>married</b>		<b>Jan. 1, 1924</b>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>31 yrs.</b>		<b>laborer</b>		<b>Farming</b>		<b>Cambridge, Maryland</b>	
IF UNDER 1 YRS. Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours		IF UNDER 24 HRS. Min.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<b>USA</b>				<b>Elwood McCarter</b>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<b>Maggie Whittington</b>				<b>no</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
-----				<b>Mrs. Maggie W. Hill--Rehobeth, Md.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
521X IMMEDIATE CAUSE (A) <b>Lung Abscess</b>							<b>2 mo.</b>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Epilepsy</b>							<b>6 years</b>
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 22, 1955</b> , to <b>Aug 27, 1955</b> , that I last saw the deceased alive on <b>Aug 17, 1955</b> , and that death occurred at <b>4:55 a.m.</b> from the causes and on the date stated above.							
SIGNATURE <b>A. N. Ban</b>			ADDRESS <b>Crisfield, Md.</b>			DATE SIGNED <b>8/28/55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF			NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>			<b>Aug. 29, 1955</b>			<b>Marumsco Cemetery</b>	
LOCATION (City, town, or county) (State)			<b>Marumsco, Md.</b>				
24. FUNERAL DIRECTOR			ADDRESS				
<b>Bradshaw &amp; Sons--Crisfield, Md.</b>							
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE				
<b>Aug. 29, 1955</b>			<b>Bartara S. Adams</b>				

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

1955

BUREAU V. S.

8079

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crisfield</b>		LENGTH OF STAY (in this place) <b>2 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Crisfield</b>		<b>39</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>McCready Hospital</b>				STREET ADDRESS (If rural give location) <b>Broadway</b>			
3. NAME OF DECEASED: (Type or Print) <b>MABLE</b> (First) <b>LANE</b> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <b>August 21 19 55</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>	8. DATE OF BIRTH: <b>1903</b>	9. AGE last birthday <b>52</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Industry</b>		11. BIRTHPLACE (State or foreign country): <b>Marumsc, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME: <b>John E. Lane</b>				14. MOTHER'S MAIDEN NAME: <b>Florence Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Doris Lane—Crisfield, Md.</b>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Carcinoma pancreas</b>						<b>3-4 mo.</b>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Jaundice</b>						<b>10 days</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 1, 1955</b> to <b>Aug 21, 1955</b> , that I last saw the deceased alive on <b>Aug 21, 1955</b> , and that death occurred at <b>2:20a</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Ch. Krawley M.D.</b>				ADDRESS <b>Crisfield, Md.</b>		DATE SIGNED <b>Aug 22, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Aug 22, 1955</b>		REGISTRAR'S SIGNATURE <b>Barbara L. Adams</b>		24. FUNERAL DIRECTOR <b>Bradshaw &amp; Sons—Crisfield, Md.</b>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 29 1955

BUREAU V. S.

8070

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
39 TOWN <u>Crisfield</u>		lifetime		39 TOWN <u>Crisfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 Maple St.				Maple St.			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>IVA</u>		(Middle) <u>MAE</u>		(Last) <u>PARKS</u>			
(Type or Print)				OF DEATH: <u>August</u>		<u>8</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	widowed	Jan. 15, 1875	80 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
housewife				Domestic		Crisfield, Md.	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas Dize				Martha Miles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				none			
17. INFORMANT & ADDRESS:				Norris Tawes-N. Somerset Ave.-Crisfield, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
(A) <u>Coronary Disease</u>							
DUE TO							
(B) <u>Arterio Sclerosis</u>							
DUE TO							
(C) <u>(Obstruction)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Natural Cause</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
K				K			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
				21C. WHERE (City or town) INJURY OCCURRED			
				William H. Coulbourn, M.D.			
				DEPUTY MEDICAL EXAMINER			
				FOR SOMERSET COUNTY, MD.			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work			
				M.			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased <u>she was dead before</u> <u>that I saw the deceased</u> <u>alive or</u> <u>19</u> <u>and that death occurred at</u> <u>3:45 P.M.</u> <u>from the causes and on the date stated above.</u>							
SIGNATURE <u>William H. Coulbourn</u> M.D. <u>Crisfield Somerset Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 10, 1955		Crisfield Cemetery		Crisfield, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Aug 10, 1955		<u>Bartow S. Adams</u>		Bradshaw & Sons-Crisfield, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 15 1955

RECEIVED

8071

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>39 Crisfield</b>		LENGTH OF STAY (in this place) <b>lifetime</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>39 Crisfield</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 S. First St.</b>				STREET ADDRESS (If rural give location) <b>1 S. First St.</b>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <b>ELLSWORTH THOMAS POWELL</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>August 19 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>Jan. 29, 1893</b>	9. AGE last birthday <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country): <b>Crisfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Isaac Powell</b>				14. MOTHER'S MAIDEN NAME: <b>Annie Mister</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>S. First St. Mrs. Annie M. Powell—Crisfield, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>150x Hemorrhage from Chest</b>						<b>2 hours</b>	
ANTECEDENT CAUSE (S) DUE TO (B) <b>Carcinoma of Esophagus</b>						<b>7 mo.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>May 1955</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma (U.S.P.H.S. 1 King. Balt., Md.)</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Mar. 26, 1955</b> , to <b>Aug. 19, 1955</b> , that I last saw the deceased alive on <b>Aug. 19, 1955</b> , and that death occurred at <b>3:45p M.</b> from the causes and on the date stated above. SIGNATURE <b>A. W. Bam</b> M.D. ADDRESS <b>Crisfield, Md.</b> DATE SIGNED <b>Aug 24, 1955</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 21, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>American Legion Cemetery</b>		LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Aug 21, 1955</b>		REGISTRAR'S SIGNATURE <b>Barbara S. Adams</b>		24. FUNERAL DIRECTOR ADDRESS <b>Bradshaw &amp; Sons—Crisfield, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 25 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8980  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 08083  
No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Somerset</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Dames Quarter</u>		<u>2 1/2</u>		TOWN <u>Dames Quarter</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				/			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Clara Rosina Wallace</u>				(Month) (Day) (Year) <u>Aug 2 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>white</u>		<u>Married</u>		<u>Aug 1 - 1955</u>	
9. AGE last birthday:				10. BIRTHPLACE (State or foreign country):			
yrs. Months Days				U.S.A.			
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				12. CITIZEN OF WHAT COUNTRY?			
<u>Body -</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Adolphe Wallace</u>				<u>Marlene Whigfall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
<u>no</u>							
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Adolphe Wallace Dames Quarter Md</u>				19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
				INTERVAL BETWEEN ONSET AND DEATH			
757.3 Immediate cause				(a) <u>Pneumonia</u>			
				DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last				(b) <u>Picornate uterus</u>			
				DUE TO			
				(c)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER DATE SIGNED			
<u>R.H. Johnson</u>				<u>Aug 2 - 55</u>			
M. D. DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 2, 1955</u>		<u>Dames Quarter Cem.</u>		<u>Dames Quarter, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8/3/55</u>		<u>R. H. Johnson, M.D.</u>		<u>Adolphe S. Wallace (father)</u>		<u>Dames Quarter, Md.</u>	

**CRIMINAL RECORD INFORMATION**

This form is to be completed by the local law enforcement agency having jurisdiction over the area in which the crime was committed. It should be filled out as soon as possible after the crime and should be forwarded to the FBI as soon as possible.

1. NAME OF DEATH		2. PLACE OF DEATH	
3. NAME OF DECEASED (Last, first, middle initial)		4. DATE OF DEATH (Month, day, year)	
5. SEX		6. COLOR	
7. HEIGHT (Feet, inches)		8. WEIGHT (Pounds)	
9. BUILD		10. HAIR	
11. EYES		12. SKIN	
13. OCCUPATION (If deceased was engaged in a profession, trade, or occupation, state it)		14. EDUCATION (If deceased was educated, state it)	
15. MARITAL STATUS (Single, married, widowed, divorced, etc.)		16. RELIGION	
17. BIRTH DATE (Month, day, year)		18. BIRTH PLACE	
19. FATHER'S NAME		20. MOTHER'S NAME	
21. SOCIAL SECURITY NUMBER		22. MARITAL STATUS	
23. DATE OF DEATH		24. TIME OF DEATH	
25. PLACE OF DEATH		26. CAUSE OF DEATH	
27. MANNER OF DEATH		28. MEDICAL HISTORY	
29. TOXICOLOGY		30. ALCOHOL	
31. DRUGS		32. OTHER	
33. SIGNATURE OF EXAMINER		34. DATE	

**RECEIVED**  
**BUREAU V. S.**  
 AUG 4 1955

**MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

8081

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Somerset</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>X</b> <b>TOWN</b> <b>Rehobeth</b>		<b>lifetime</b>		<b>Rehobeth</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>00</b>				<b>/</b>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <b>SILAS</b>		(Middle)		(Last) <b>WHITTINGTON</b>			
(Type or Print)				OF DEATH: <b>August 19</b>		<b>19 55</b>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>Male</b>		<b>Colored</b>		<b>widowed</b>		<b>1885</b>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<b>70</b> yrs.		Months   Days   Hours   Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Seafood Industry</b>		11. BIRTHPLACE (State or foreign country): <b>Rehobeth, Md.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>James H. Meeshack</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Tilghman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY No.			
				17. INFORMANT & ADDRESS: <b>John H. Whittington—Rehobeth, Md.</b>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cerebral Vascular Accident</b>							
ANTECEDENT CAUSE (S) DUE TO (B) <b>Generalized Arteriosclerosis &amp; Hypertension</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Prostatic Hypertrophy, Cystitis</b>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7/22</b> , 19 <b>53</b> , to <b>8/19</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/12</b> , 19 <b>55</b> , and that death occurred at <b>11:30 P.</b> from the causes and on the date stated above.							
SIGNATURE <b>A. N. Ban</b>				DATE SIGNED <b>8/22/55</b>			
M. D. <b>Crisfield, Md.</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>August 22, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Marumsco Cemetery</b>		LOCATION (City, town, or county) (State) <b>Marumsco, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>August 22, 1955</b>		REGISTRAR'S SIGNATURE <b>Barbara L. Adams</b>		24. FUNERAL DIRECTOR ADDRESS <b>Bradshaw &amp; Sons—Crisfield, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 25 1955

BUREAU V. S.